



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Kent Landon Mitchell

Respondent Name

LM Insurance Corp

MFDR Tracking Number

M4-16-2319-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

April 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "due to the Services that we provide with Pain Management the Services are considered to be Medical Necessary and the documentation is attached, to support the Laboratory Services that were ordered."

Amount in Dispute: \$659.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charges for (claimant) for services of July 8, 2015 were denied as not medically necessary per peer review. This is not a matter for Medical Fee Dispute resolution."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2015	Urinary Drug Screening	\$659.16	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.305 sets our general guidelines for medical dispute resolution.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - X435 – Based on peer review, further treatment is not recommended.
 - 193 – Original payment decision is being maintained.
 - X598 – Claim has been re-evaluated on additional documentation submitted; no additional payment due.

Issues

1. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity?
2. What is the dispute process for resolving medical necessity denials?
3. What is the dispute sequence?
4. What are the filing requirements after the resolution of a medical necessity denial?
5. Are the disputed services eligible for review by Medical Fee Dispute Resolution?

Findings

1. The medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for a claim with date of service July 8, 2015 for which there is a medical fee dispute. Review of the EOBs presented by the both the requestor and respondent indicate denial reason code(s) "X435 - Based on the findings of a review organization."
2. **Resolution of a Medical Necessity Dispute.** The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under **Health Care Providers or their authorized representatives.**
3. **Notice of Dispute Sequence.** 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding...medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding...medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.
4. The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.
5. 28 Texas Administrative Code §133.307(f) (3) states in pertinent part, "The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of this section." Kent Landon Mitchell has the right to submit a new medical fee dispute after the medical necessity issue is resolved. Kent Landon Mitchell is responsible for filing for medical fee dispute not later than 60 days after the date the requestor receives the final Division decision. The 60-day filing requirement described in 28 Texas Administrative Code §133.307(c)(1)(B)(i) replaces the one-year filing deadline in those cases where a final decision regarding medical necessity is made. The division finds that due to the unresolved medical necessity issues, the medical fee dispute request for date of service July 8, 2015 is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 28, 2016
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.